



COVERED SERVICES

NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. For answers to specific questions regarding covered services, limitations, and exclusions, consult the [*AHCCCS Medical Policy Manual*](#) or contact the AHCCCS Office of Special Programs at (602) 417-4053.

AHCCCS covers medically necessary services provided in nursing facilities for those acute care recipients who need nursing care 24 hours a day but who do not require hospital care under the daily direction of a physician.

AHCCCS covers up to 90 days of nursing facility services per contract year (October 1 through September 30) for fee-for-service acute care recipients who have not been determined eligible for ALTCS when the following requirements are met:

- ☒ A physician has ordered nursing facility services in lieu of hospitalization.
- ☒ The medical condition of the recipient is such that, if nursing facility services are not provided, it would result in hospitalization of the individual.
- ☒ Services cannot be effectively provided in the home or in an Indian Health Service (IHS) facility due to lack of appropriate equipment or qualified staff.
- ☒ For recipients enrolled in IHS, an IHS referral has been obtained by the nursing facility documenting the reasons for nursing facility placement.
- ☒ For hospitalized recipients, the hospital personnel have coordinated patient teaching, discharge planning, and transfer in a timely manner.
- ☒ The recipient needs care or constant monitoring by a registered nurse.
- ☒ The recipient requires assistance with care that cannot be self-administered or provided by a caregiver in the home.

Each facility is responsible for coordinating the delivery of ancillary services, including medical services, pharmaceutical services, therapies, diagnostic services, emergency services, and medically necessary transportation.



COVERED SERVICES (CONT.)

The following services are commonly included in the nursing facility per diem rate. The list includes but is not limited to:

- ☒ Nursing services, including rehabilitative and restorative services which include:
 - ✓ Administration of medication
 - ✓ Tube feedings
 - ✓ Personal care services (assistance with bathing, grooming, and laundry)
 - ✓ Routine testing of vital signs
 - ✓ Assistance with eating
 - ✓ Maintenance of catheters
 - ✓ Over the counter medications
- ☒ Social services, activity and recreational services, and spiritual services
- ☒ Rehabilitation therapies
- ☒ Nutritional and dietary services including, but not limited to, preparation and administration of special diets and adaptive tools for eating
- ☒ Medical supplies and durable medical equipment
- ☒ Overall management and evaluation of the care plan
- ☒ Observation and assessment of a recipient's changing condition
- ☒ Room and board services including, but not limited to, support services such as food, personal laundry, and housekeeping
- ☒ Administrative physician visits solely for the purpose of meeting state licensure
- ☒ Non-prescription, stock pharmaceuticals

The following items are also included in the per diem rate. The list includes but is not limited to:

- ☒ Accucheck monitors
- ☒ Alternating pressure mattress and pump
- ☒ Bedside commode
- ☒ Canes (all types)
- ☒ Crutches
- ☒ Cushions



COVERED SERVICES (CONT.)

Supplies and equipment included in nursing facilities per diem reimbursement (Cont.):

- ☒ Emesis basins
- ☒ Feeding pumps
- ☒ Foot cradles
- ☒ Geri-chairs (all non-customized)
- ☒ Heating pads
- ☒ Hospital beds (electric and manual)
- ☒ Nebulizers
- ☒ Lifts
- ☒ Suction machines
- ☒ IV poles
- ☒ Walkers (all non-customized)
- ☒ Water mattresses
- ☒ Wheelchairs (all non-customized)

Items included in the per diem rate may not be separately billed. Covered services that are not part of the per diem rate may be billed when ordered by the attending physician and specified in the case management plan.

LIMITATIONS

The following limitations apply to nursing facility services.

- ☒ Private rooms in nursing facilities are limited to medical conditions that require isolation per physician orders.
- ☒ Therapeutic leave days are limited to nine days per contract year.
- ☒ Bed hold days for recipients admitted to a hospital for a short stay are limited to 12 days per contract year.
- ☒ Services or items requiring authorization for which authorization has not been obtained are not covered.



AUTHORIZATION FOR SERVICES

The AHCCCS Administration does not authorize any services rendered by Indian Health Service (IHS). For nursing facility services rendered by tribal providers to acute fee-for-service IHS members, PA from AHCCCS is required unless the recipient becomes retroactively eligible for AHCCCS.

Providers may phone or fax the AHCCCS PA Unit to request authorization. To obtain PA by telephone, providers must call between 8:30 a.m. and 4:30 p.m. Monday – Friday:

(602) 417-4400 (Phoenix area) Providers in area codes 602, 480, and 623 **must** use this number.

1-800-433-0425 (within Arizona) This number is blocked for callers in area codes 602, 480, and 623.

1-800-523-0231 (outside Arizona)

The AHCCCS PA Unit's fax number is (602) 256-6591.

Initial authorization will not exceed the recipient's anticipated fee-for-service enrollment period or a medically necessary length of stay, whichever is shorter. Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.

BILLING FOR SERVICES

Nursing facilities cannot submit claims that overlap months.

AHCCCS only pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.

Nursing facilities must bill for room and board services on the UB-92 claim form. The table on Page 15-5 summarizes the allowable revenue codes and bill types, effective with dates of service on and after October 1, 2003.



BILLING FOR SERVICES (CONT.)

Revenue Codes	Allowable Bill Types
190 Subacute General	86X
191 Subacute Care Level I	110 – 179, 211 – 228, 611 - 628
192 Subacute Care Level II	110 – 179, 211 – 228, 611 - 628
193 Subacute Care Level III	110 – 179, 211 – 228, 611 - 628
194 Subacute Care Level IV	110 – 179, 211 – 228, 611 - 628
199 Other Subacute Care	651 - 678
183 LOA – Therapeutic (For home visit by recipient)	211 – 228, 611 - 628
185 LOA – Bed hold (For short-term hospitalization)	211 – 228, 611 - 628

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-92 claim forms using the appropriate bill types and patient status codes.

Example 1:

A recipient residing in a skilled nursing facility is hospitalized on April 11. The recipient is discharged from the hospital on April 14 and returns to the nursing facility that day. The recipient remains in the nursing facility through April 30. When billing for the month of April, the nursing facility would submit the following three claims to AHCCCS:

First claim

Dates: 04/01 - 04/10 Bill Type: 212
Revenue code: 192 Patient status: 30

Second claim

Dates: 04/11 - 04/13 Bill Type: 213
Revenue code: 185 Patient status: 02

Third claim

Dates: 04/14 - 04/30 Bill Type: 214
Revenue code: 192 Patient status: 30

When Medicare is the primary payer, AHCCCS will pay the full Medicare coinsurance amount minus any other third party payment. Payment will equal the full Medicare coinsurance amount for the covered days. The Medicare allowed amount includes all ancillary services covered under the Medicare per diem. Providers should not bill separately for those ancillary services.

NOTE: See [Chapter 7, Medicare/Other Insurance Liability](#), for detailed information on billing nursing facility claims with Medicare.